Supreme Court, U.S.
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No. 93-1695

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1993

DOROTHY E. TRAVITZ,

Petitioner,

v.

NORTHEAST DEPARTMENT ILGWU
HEALTH AND WELFARE FUND
AND
ILGWU EASTERN STATES
HEALTH AND WELFARE FUND,

Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE THIRD CIRCUIT

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether ERISA's preemption provisions, as interpreted by this Court in *FMC Corp. v. Holliday* and *Metropolitan Life Insurance Co. v. Massachusetts,* prohibit states from applying state insurance regulations to self-funded employee welfare benefit plans?

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STATUTES INVOLVED

In addition to the statute cited in the Petition for Writ of Certiorari, Section 1719(b) of the Pennsylvania Motor Vehicle Financial Responsibility Law ("Pa. Law") provides:

> "(b) Definition.—As used in this section the term 'program, group contract or other arrangement' includes, but is not limited to, benefits payable by a hospital plan corporation or a professional health service corporation subject to 40 Pa.C.S. Ch. 61 (relating to hospital plan corporations) or 63 (relating to professional health services plan corporations)."

STATEMENT OF THE CASE

Prior to January 1, 1990, the Fund was known as the Northeast Department ILGWU Health and Welfare Fund. As of January 1, 1990, the Northeast Department Fund was merged into the ILGWU Eastern States Health and Welfare Fund (hereinafter collectively "the Fund"). The Fund is an employee welfare benefit plan existing for the purpose of providing hospital, medical/surgical, major medical, weekly disability, dues-made-good, preventative health care, eyeglass, and vacation benefits to employees of contributing employers covered by collective bargaining agreements. Benefits distributed by the Fund are funded by employer contributions and by investment income earned on employer contributions.

The Fund is a self-insured, multiemployer plan to which thousands of employers, primarily in the ladies' apparel industry, make contributions pursuant to collective bargaining agreements between such employers and the International Ladies' Garment Workers' Union. Dorothy E. Travitz was, on or about October 18, 1990, a participant of the Fund.

The fiscal integrity of the Fund is maintained through, among other ways, excluding from coverage certain types of claims for benefits. The Fund contains various exclusions from coverage including, among others, an exclusion pertaining to conditions for which costs of treatment or losses are recoverable through legal action or claims settlement from another party or insurance company.

The Fund provides as follows:

> **"General Exclusions and Limitations**
>
> "The information in this section applies to all of the benefits that the Fund offers. It is not repeated in each specific section, but it applies anyway.
>
> **Exclusions"**

* * *

"(5) You can not receive benefits/coverage for a condition if the costs of treating that condition are recoverable through legal action or claim settlement from another party or insurance company."

The Fund further provides for a temporary advance of benefits pending litigation or claims settlement with respect to injuries or illnesses otherwise excluded from coverage under the Fund, in order to assist the participant during delays in recovering the payment for those excluded conditions from a third party. The Fund terms require that in the event of recovery from a third party, the Fund must be reimbursed to the full extent of advanced benefits, without a deduction for attorneys' fees incurred by the participant in third-party litigation related to the excluded conditions.

The Fund provided as follows:

"Advance of Benefits

"If you have a right to recover payment for an injury or illness from another source, there may be delays because of the time it takes to process the claim or because of lawsuits. If this happens, the Fund may be able to help you temporarily by paying benefits in advance. If this is done, you must sign a legal document stating that the Fund will be repaid in full, from any settlement you receive. The Fund must be repaid to the full extent (without any deduction of attorney fees, court costs, or arbitration costs) of the benefits it provided. The Fund may also require legal assurances that the party which is liable to you will honor your claim and that the money due to you will be repaid directly to the Fund. In all cases, only the Trustees of the Fund can decide whether an

> advance of benefits is appropriate. Each case will be decided on its own merits.
>
> "If you are denied benefits from the Fund because the Fund or its agents believe that payment is recoverable from another source, you may appeal that decision directly to the Board of Trustees. See page 49 for information on the procedure for this type of appeal."

Subsequent to October 18, 1990, the Fund received numerous claims for benefits from Dorothy Travitz relating to treatment or services for injuries resulting from the use of a motor vehicle on October 18, 1990.

The Fund initially began to process the payment of claims submitted by Travitz pursuant to the Advance of Benefits provisions of the Plan. The Fund paid a total of $2,924.78 of benefits for Travitz relating to the treatment or services for in juries resulting from the October 18, 1990 motor vehicle accident.

Subsequent to October 18, 1990, the Fund sought assurances from Travitz and her attorney that, if the Fund was to advance benefits, the participant and counsel would recognize and protect the Fund's interest in the benefits advanced to participant. By letter dated April 12, 1991, counsel for the Fund wrote to counsel for Travitz advising him of the Fund's position and requesting that Travitz execute an Assignment of Claim form enclosed in the letter. Despite the request by Fund and Fund's counsel for participant to execute the Assignment of Claim, participant refused to executed the form. Subsequent to October 18, 1990, Travitz submitted to the Fund bills for treatment or services resulting from injuries sustained by her in the October 18, 1990 motor vehicle accident requesting that the bills be paid by the Fund. In view of Travitz's refusal to execute the Assignment of Claim, the Fund ceased advancing benefits and did not pay any additional bills submitted by Travitz.

Subsequent to October 18, 1990, Travitz asserted tort claims against certain tortfeasors alleging that the

motor vehicle accident occurring on October 18, 1990, and the resulting physical and personal injuries to Travitz, arose out of certain negligent acts or omissions of the tortfeasors.

By letters dated April 12, 1991, June 3, 1992, June 17, 1992, and July 10, 1992, counsel for the Fund wrote to counsel for Travitz detailing the Fund's position with respect to: (1) the Fund's exclusionary provisions relating to treatment or services for injuries resulting from recoveries through legal action or claim settlement from another party or insurance company; (2) the Fund's advance of benefits provisions; (3) the Fund's federal common law right of subrogation; and (4) that the Employee Retirement Income Security Act preempts the application of the Pennsylvania Motor Vehicle Financial Responsibility Law to the Fund, since it is a self-insured employee welfare benefit plan, as held by this Court in *FMC Corp. v. Holliday,* 498 U.S. 52 (1990).

Prior to the settlement of Travitz's tort claim, the June 3, 1992 letter detailed at length the position of the Fund with respect to the Fund's interpretation and application of the Fund's exclusion provisions. Counsel for Travitz was advised as follows:

> "The Fund is a self-insured employee welfare benefit fund which does not purchase an insurance policy from any insurance company in order to satisfy its obligations to its participants. In *FMC Corporation v. Holliday,* ____ U.S. ____, 111 S.Ct. 403, 107 L.Ed. 2d 356 (1990), the Supreme Court held that ERISA preempts the application of Pennsylvania state law to self-funded employee benefit plans. Although state laws directly regulating insurance are not preempted under ERISA, the Act also provides that self-funded employee benefit plans may not be deemed to be insurance companies or engaged in the business of insurance for purposes of such state laws. Thus the

Fund, being self-insured, is not subject to the Pennsylvania automobile insurance laws.

"Accordingly, since Pennsylvania insurance law is preempted by ERISA with respect to the Fund, the rules under the Fund's plan take primary effect. A copy of the general exclusions and limitations language found in the Fund's Summary Plan Description is enclosed for your review. Paragraph 3 excludes all Fund benefits 'for treatment or services for injuries resulting from the maintenance or use of a motor vehicle if such treatment or service is paid under a plan or policy of motor vehicle insurance.' Therefore, the Fund is not responsible for paying benefits that would be payable to Mrs. Travitz under the auto insurance coverage.

"Moreover—and more importantly—under Paragraph 5, Mrs. Travitz 'cannot receive benefits/coverage for a condition if the costs of treating the condition are recoverable through legal action or claim settlement from another party or insurance company.' Thus, benefits are not payable to your client for medical treatment arising out of the automobile accident on October 18, 1990."

On June 17, 1992, Travitz entered into a Settlement Agreement and Release with the tortfeasors and their insurer. By virtue of the Release, Travitz received the following payments, or will receive the following payments:

2. ***Payments***

In consideration of the release set forth above, the Insurer on behalf of the Defendants agrees to pay to the individual(s) named below ("Payee(s)") the sums outlined below:

(A) Immediate cash: $125,000.00

(B) The Periodic Payments shall be deemed paid when mailed by First Class Mail on the dates specified as follows:

- $1,030 per month for life with 15 years guaranteed, compounding 3% annually, commencing 4-20-1992.
- $10,000 payable on 4-20-1997, guaranteed.
- $15,000 payable on 4-20-2002, guaranteed.
- $20,000 payable on 4-20-2007, guaranteed.
- $30,000 payable on 4-20-2013, guaranteed.

Notwithstanding the significant recovery of settlement proceeds by Travitz, the Fund was never notified of the recovery. Furthermore, no portion of the advanced benefits were reimbursed to the Fund.

Subsequent to June 17, 1992, Travitz initiated suit against the Fund in the United States District Court for the Middle District of Pennsylvania seeking payment of all medical bills that she incurred arising out of the October 18, 1990 automobile accident. Travitz asserted that Section 1722 of the Pa. Law precluded her from recovering the cost of the medical benefits from the tortfeasor since the benefits were payable by the Fund, regardless of the coverage exclusion of the Fund. The Fund responded by arguing that Exclusion 5 was applicable to Travitz, since Section 1722 of the Pa. Law was preempted by ERISA, and that Travitz therefore should have sought recovery from the tortfeasor for the medical bills.

Both Travitz and the Fund moved for summary judgment. The District Court found that there were no disputed material facts, granted the Fund's Motion, and denied Travitz's Motion. The Court of Appeals affirmed the District Court's decision, holding that the application of Section 1722 of the Pa. Law to the Fund was preempted by ERISA since Section 1722 attempts to shift liability for medical and health care benefits to the Fund.

SUMMARY OF ARGUMENT

In enacting ERISA's expansive preemption provision Congress intended to preempt all state laws which relate to self-funded employee benefit plans. Section 1722 of the Pa. Law relates to the Fund since it has a direct economic impact upon the Fund by effectively mandating that the Fund must pay all of Travitz's medical benefits despite the explicit exclusionary language in Exclusion 5. If the Fund was required to follow the provisions of Section 1722 of the Pa. Law in Pennsylvania, it would be subject to potentially inconsistent participant coverage requirements. This Court, in FMC Corp., found that in enacting the preemption provisions Congress did not intend to have self-insured employee benefit plans subject to a "patchwork scheme of regulation" on a state-to-state basis.

REASONS FOR DENYING THE WRIT

There are no special and important reasons for granting the Writ, since the decision of the Court of Appeals for the Third Circuit is consistent with the Court's opinions in *FMC Corp.* and *Metropolitan Life Insurance Co.*, and therefore does not conflict with a decision of another court of appeals or conflict with a decision of this Court.

The decision of the Court of Appeals for the Third Circuit, affirming that of the United States District Court for the Middle District of Pennsylvania, is consistent with this Court's decision in *FMC Corp. v. Holliday,* 498 U.S. 52 (1990) and *Metropolitan Life Insurance Co. v. Massachusetts,* 471 U.S. 724 (1985). There is no conflict or any other basis for further review of the issues raised below and herein by this Court.

Moreover, Travitz fails to articulate what substantial question she is seeking to have this Court review. Rule 11 of this Court addresses the consideration governing

the grant or denial of certiorari. The Rule emphasizes the necessity of a substantial question before certiorari will be granted. The Rule sets forth a list of reasons which clearly indicate the character of the reasons that it will consider in whether to grant certiorari. The issues that Travitz raises in her Petition do not establish that the decision of the Court of Appeals conflicts with any decisions of other circuits or raises an important question of federal law which has not been settled by this Court.[1] The issues raised by the Petition had been addressed and settled by the Court in *FMC Corp.*, 498 U.S. 52 (1990) and *Metropolitan Life Insurance Co.*, 471 U.S. 724 (1985).

This case is therefore not appropriate for the Supreme Court to review, and therefore the subject Petition for Writ of Certiorari should be denied.

Despite this Court's decisions in *FMC Corp.*, which reaffirmed and reinforced its decision in *Metropolitan Life* that the application of the Pennsylvania law to a self-insured employee welfare benefit plan was preempted by ERISA, Travitz suggests that this holding should be revisited herein.

In *Metropolitan Life,* this Court held that ERISA preempts the application of state insurance laws to uninsured, or self-funded employee welfare benefit plans. In so doing, this Court gave life to the distinction between insured and self-insured plans which Congress

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1. Since *FMC Corp.*, the courts have uniformly found that ERISA preempts any attempt to regulate self-insured employee benefit plans. *Hampton Industries v. Sparrow,* 981 F.2d 726 (4th Cir. 1992); *Lincoln Mutual Casualty Co. v. Lectron Products, Inc. Employee Health Benefit Plan,* 970 F.2d 206 (6th Cir. 1992); *Autoclub Insurance Association v. Health and Welfare Plans, Inc.,* 961 F.2d 588 (6th Cir. 1992); *PM Group Life Insurance v. Western Growers Assurance Trust,* 953 F.2d 543 (9th Cir. 1992); *Provident Life and Accident Insurance Co. v. Linthicum,* 930 F.2d 14 (8th Cir. 1991); *Thompson v. Talquin Building Products Co.,* 928 F.2d 649 (4th Cir. 1991).

created in the so-called "deemer clause" of ERISA, Section 514(b)(2)(B).

In *Metropolitan Life,* this Court employed a three-part analysis following the structure of Section 514 in considering whether state regulation of self-insured benefit plans is preempted by ERISA. First, Section 514(a), ERISA's broad preemption provision, provides that ERISA shall preempt "any and all state laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. §1144(a). "The phrase 'relate to' was given its broad common-sense meaning, such that a state law 'relate[s] to' a benefit plan 'in the normal sense of the phrase, if it has a connection with or reference to such plan.' " *Metropolitan Life,* 471 U.S. at 739 quoting *Shaw v. Delta Airlines, Inc.,* 463 U.S. 85, 97 (1983).

Second, Section 514(b)(2)(A), the so-called insurance savings clause, provides that ERISA does not preempt any state law "which regulates insurance, banking or securities law." 29 U.S.C. §1144(b)(2)(A). A state law "regulates insurance" if it meets the common-sense requirement that it is specifically directed towards some aspect of the insurance industry or if it falls within the reference in the McCarran-Ferguson Act, 15 U.S.C. §1011, *et seq.,* to the "business of insurance." *Metropolitan Life,* 471 U.S. at 742-43.

Third, Section 514(b)(2)(B), ERISA's deemer clause, limits the reach of the insurance savings clause, providing "neither an employee benefit plan nor any trust established under such a plan, shall be deemed to be an insurance company . . . for the purposes of any law of any state purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. §1144(b)(2)(B). Thus, this Court's analysis in *Metropolitan Life* established a bright line test relating to preemption as between insured and self-insured employee benefit funds. As the Court stated,

> "Our decision results in a distinction between insured and uninsured plans, leaving the

> former open to indirect regulation while the latter are not. By so doing, we merely give life to the distinction Congress is aware of and one it has chosen not to alter."

Id. at 474 (footnote omitted).

By so concluding, this Court recognized that Congress established benefit plan regulation as exclusively a federal concern to minimize the need for interstate self-insured funds such as the Fund to administer their plans differently in each state in which they have participants. This recognized the administrative realities of self-insured, multi-state employee benefit plans, and sought to promote a fund's capacity to provide benefits to participants scattered throughout many states in the most efficient manner—i.e., through a single employee benefit plan. As this Court stated in *Fort Halifax Packing Co., Inc. v. Coyne,* 482 U.S. 1, 11 (1987):

> "It is thus clear that ERISA's preemption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies and benefit program operation, which might lead these employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them. Preemption ensures that the administrative practices of a benefit plan will be governed by only a single set of regulations."

In *FMC Corp.,* this Court was called upon to revisit the issue of whether the ERISA deemer clause protects selfinsured employee benefit plans from all state insurance regulation. In *FMC Corp.,* this Court considered whether ERISA preempted Section 1720 of the Pa. Law—i.e., anti-subrogation provision—which specifically prohibited an insurer from collecting funds from a

plaintiff in satisfaction of its subrogation interest when the plaintiff had been injured and obtained recovery in an action arising out of the maintenance or use of a motor vehicle. Following its three-step analysis set forth in *Metropolitan Life,* this Court concluded that Section 1720 " 'relate[s] to' an employee benefit plan" since Section 1720, as does Section 1722 herein, has a "reference" to employee benefit plans, as does Section 1722, and a "connection" to employee benefit plans, as does Section 1722. Travitz is asserting that while this Court found that ERISA preempted Section 1720 of the Pa. Law, the preemption provisions of ERISA do not preempt the application of Section 1722 of the Pa. Law to the Fund, despite the Pa. Law's specific reference to employee welfare benefit plans in Section 1722 of the Law.

Travitz acknowledges and concedes in the Petition that Section 1722 of the Pa. Law contains a "reference to" an employee welfare benefit plan. Despite conceding that Section 1722 of the Pa. Law makes "reference to," and thus "relates to" the Fund and is therefore preempted by Section 514(a) of ERISA, Travitz goes on to argue that there is no "connection with" the Fund. Under the Court's test in *Shaw v. Delta Airlines, Inc.,* Travitz's queries and arguments relating to Section 514(a) of ERISA should have stopped at that point. The court below, in concluding that Section 1722 of the Pa. Law not only made "reference to" but was "connected with" the Fund, found that:

> Section 1722, which precludes the recovery of benefits from a tortfeasor where a person is eligible to receive those benefits under another program, group contract or arrangement, as defined in Section 1719, has 'reference' to benefit plans governed by ERISA. . . ."
>
> * * *
>
> "In addition, Section 1722 has a 'connection' to ERISA benefit plans. The Court has

> held that state laws have a 'connection' to an ERISA plan when the laws risk subjecting plan administrators to conflicting state regulations. . . . Section 1722 has that very effect."

There is a clear "connection with" the Fund that is not "too tenuous, remote or peripheral," since one of the objects of Section 1722 of the Pa. Law when there are injuries to an individual and there are resulting medical charges is to dictate the order of coverage/recovery under various policies of insurance, i.e., first-party benefits mandated by Subchapter B of the Pa. Law, workers' compensation and benefits paid by a program, group contract, or other arrangement. Section 1719, Coordination of Benefits, says that the first-party benefits mandated by Subchapter B shall be primary with respect to all other policies of insurance except workers' compensation, which shall always be primary over the first-party benefits. Section 1719 goes on to say that all other policies of insurance covering the individual, i.e., "programs, group contracts or other arrangements," shall be deemed to contain a provision in the policy of insurance that its benefits shall be in excess of the first-party benefits.

In Section 1720, Subrogation, and 1722, Preclusion of Recovering Required Benefits of the Law, the Pennsylvania legislature went on to dictate that in situations where there is litigation arising out of the maintenance or use of a motor vehicle and the individual incurs medical bills, the individual or a program, group contract or other arrangement may not recover medical benefits paid or payable because of injuries sustained by the individual.

The ultimate object of Sections 1720 and 1722 is to shift the responsibility for the payment of medical bills to either the workers' compensation carrier or to some third-party carrier, i.e., a program, a group contract, or an other arrangement – the Fund as asserted by Travitz.

By enacting these provisions, the Pennsylvania legislature is dictating the structure and the terms of coverage of employee benefit plans.

What this Court said in *FMC Corp.*, is that Section 512 of ERISA prohibits this shifting by the Pa. Law of responsibility for the payment of medical bills to self-insured employee welfare benefit plans or the waiver of federal common law subrogation rights of self-insured employee welfare benefit plans. This Court concluded that Section 512 prohibited the Pennsylvania legislature from attempting to mandate plan design and coverage for self-insured employee welfare benefit plans.

The ultimate object of the self-insured employee welfare benefit plan in *FMC Corp.*, and the Fund herein, was to avoid being ultimately responsible for the payment medical charges where there has been or may be a recovery from a party ultimately responsible for the injuries. The fund in *FMC Corp.* chose not to exclude from coverage the costs of treating the injuries sustained in an automobile accident, as did the Fund herein. The *FMC Corp.* fund took the approach of agreeing to cover these charges, and if there was a recovery from a third party they would be subrogated to that recovery. Since the benefits were covered, subrogation was the controlling theory in *FMC Corp.* Here, the benefits were not covered. The advance of benefits provision, unlike subrogation provision is directed solely at excluded benefits advanced under that unique provision. The Fund here took a different approach to ultimately achieve the same result and excluded coverage for treatment from injuries arising out of automobile accidents if the costs of treating the injury were recoverable through legal action or claims settlement. In addition, the Fund also provided that in certain circumstances where certain benefits were excluded it would advance benefits to the participant and the participant would repay the Fund from any settlement or recovery against a third party.

The result achieved by both approaches was the same, and neither approach is subject to the application of the Law.

This case is a mirror image of the *FMC Corp.* case. The Courts below recognized this fact and correctly concluded that Section 1722 of the Pa. Law was pre-empted by ERISA.

CONCLUSION

The Writ of Certiorari should not be granted in this case since there is no important question of federal law or any conflict with any other court of appeal to be settled by this Court.

Respectfully submitted,

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